## Beacon Health Options/Blue Shield of California Promise Health Plan
## Primary Care Physician Referral Form

Referral Date:_____ PCP Name:_____ PCP Phone #: _____

Referring Provider:_____

Member Name:_____ Member ID #:_____ DOB: _____

Member's Preferred Language:_____ Member Phone #:_____(home)

☐ **Please check** to confirm member eligibility was verified _____(cell)

**TO RECEIVE A CONFIRMATION OF THIS REFERRAL'S OUTCOME,**

**PLEASE CHECK THE BOX BELOW NOTING YOUR PREFERRED METHOD AND CONTACT DETAILS.**

☐ **Email Address:** _____

☐ **FAX Number:** _____

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## Requested Referral (please use separate forms for multiple referrals)

☐ **PCP Decision Support:** Request a phone call (curbside consult) with a Beacon psychiatrist for member diagnostic or prescribing support. ***Include** med list and 2 PCP progress notes for psychiatrist review before phone call.

- *Please note preferred date/time for consult*:_____(date)_____(time)
- *Best phone number to directly call PCP*:_____

*Fax form to:* ***866.422.3413*** *OR secure email: PCPReferrals@beaconhealthoptions.com*

☐ **Outpatient Behavioral Health Services:** Refer members interested in therapy or medication management via Beacon's network when needs are outside PCP scope. Beacon coordinates with county mental health.

*Fax form to:* ***866.422.3413*** *OR secure email: PCPReferrals@beaconhealthoptions.com*

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**Request Reason** (check all that apply):

*Symptoms:*

☐ Depression/Anxiety
☐ Poor self-care due to mental health
☐ Psychosis (auditory/visual hallucinations, delusional)
☐ PTSD/Trauma
☐ Violence/Aggressive Behavior
☐ Perinatal depression and/or anxiety
☐ Abuse/CPS
☐ Suicidal Ideation
☐ Homicidal Ideation
☐ Chronic Pain
☐ Substance use type: _____
☐ Other BH symptoms: _____

*Impairments:*

☐ Difficult/Unable to complete ADLs
☐ Difficult/Unable to go to work/school
☐ Other:
☐ Difficulties maintaining relationships
☐ Legal/CPS

_____

Medications (list below or send medication list with this form):

_____

_____